Bureau of Health Care Quality and Compliance

AND DUAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS4961AGZ		B. WING		C 12/07/2010	
			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	12/01/2010	
				E DE LEON <i>A</i> S, NV 89123	VE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
Y 000	Initial Comments			Y 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 12/7/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of C.						
	The facility is licensed for seven Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was two. Two resident files were reviewed and three employee files were reviewed. The following deficiencies were identified: Y 105 SS=E		II ey				
			heck	Y 105			
	a separate personnel member of the staff o	e provided in subsection file must be kept for ear facility and must incidence with NRS 449.17	ich lude:				
	Based on record revie failed to ensure 1 of 3	ot met as evidenced by: ew on 12/7/10, the facili s employees met quirements of NRS 449	ity				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDING B. WING		С			
NVS4961AGZ					12/0	7/2010			
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA					
7TH HEAV	'EN			1205 PONCE DE LEON AVE LAS VEGAS, NV 89123					
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Y 105	Continued From page 1			Y 105					
	to 449.188 (Employee #3 - the background check located in the file was from greater than six months previous to hire). This was a repeat deficiency from the 6/17/10								
State Licensure survey. Severity: 2 Scope: 2									
Y 356 SS=F	Y 356 SS=F NAC 449.222 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key must be readily available at all times.			Y 356					
	This Regulation is not met as evidenced by: Based on observation on 12/7/10, the facility did not ensure the locks on 2 of 3 bathroom doors could be opened with a single motion (Bathroom #1 and #2).		did rs						
	This was a repeat de State Licensure surve	ficiency from the 6/17/1 ey.	0						
Severity: 2 Scop		3							
Y 621 SS=E	449.2702(4)(b) Admis	ssion Policy		Y 621					
	and 449.2754, a resid	se provided in NAC 449 dential facility shall not a the facility any person v	admit						

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		NVS4961AGZ				12/0	7/2010	
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Y 621	Continued From page 2			Y 621				
Y 859 SS=E	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 This Regulation is not met as evidenced by: NAC 449.2702 6. As used in this section: (b) "Restraint" means: (1) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (2) A manual method for restricting a resident's freedom of movement or his normal access to his body; or (3) A device or material or equipment which is attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or his normal access to his body. Based on observation, interview and record review on 12/7/10, the facility failed to ensure 1 of 2 residents were not restrained with the use of full side bed rails (Resident #1). Severity: 2 Scope: 2		Y 859					

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				A. BUILDING	· · · · · · · · · · · · · · · · · · ·		
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Y 859	Continued From page	e 3		Y 859			
	This Regulation is not met as evidenced by: Based on record review on 12/7/10, the facility failed to ensure that 1 of 2 residents received an annual physical (Resident #2). Severity: 2 Scope: 2		ity				
Y 908 SS=C	449.2746(2)(a)-(f) PF	RN Medication Record		Y 908			
	(c) The dose adminis(d) The results of the medication;(e) The initials of the(f) Instructions for add	ent as needed ving information nistration of the e administration. e of the administration; tered; administration of the caregiver; and ministering the medicat ect each current order o					
	Based on record reviewdid not ensure the me	esidents receiving as ne	ity				

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NIVS 4064 A C 7			B. WING		C 12/07/2010		
NVS4961AGZ NAME OF PROVIDER OR SUPPLIER STREET.			STREET ADD	 RESS, CITY, STA	TE, ZIP CODE	12/0	7/2010
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Y 908	Continued From page 4			Y 908			
	Severity: 1 Scope: 3	3					
Y 991 SS=F	449.2756(1)(b) Alzhe	imer's Fac door alarm		Y 991			
	NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility.						
	Based on observation failed to ensure that a installed alarms that of		door				
Y 992 SS=F	()(-)			Y 992			
	provides care to personal disease shall ensure	that: per of the staff is awake					

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Y 992	Continued From page 5			Y 992				
Y 992	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		/10,	Y 992				

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